The Problem and Place of Physical Contact in Analytic Work: Some Reflections on Handholding in the Analytic Situation

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PHYSICAL CONTACT OF ANY SORT between patient and therapist in the analytic relationship continues to be an unsettled technical and theoretical dilemma for psychoanalysis. The problem has long been complicated by its implicit linkage to the liabilities of actual physical intimacy, sexual and aggressive, between the analytic pair.

In reminder: between 1911 and 1914 Freud provided a binding technical and theoretical rationale for the analyst to remain detached and unyielding in his objectivity, to stand fast against acting upon libidinal desires for gratification stirred in either party (Freud, 1912, pp. 112–114). Above all, both parties were to speak, not act.

This assumed authority of the analyst's superior knowledge was supported by a persuasive theory about what made analysis work. This theory posited, then accepted as a given, that the analyst's consistent frustration of the patient's libidinal impulses was the way to achieve the desired regression of the patient to those earlier psychic states in which crucial pathological formations had been set in place. Only from within this analyst-induced frustration state could the patient truly rework old pathology in the benign presence of the neutrally posed analyst.

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A cliche of my training years in the late 1940s went like this: "Find out what the patient wants, and then don't give it to him."

As corollary and opposite, it was dangerous for the analyst to gratify the desires of either party. For the patient, actual fulfillment would surely short-circuit the analytic process by cutting off access to the depths needed for analysis to be effective. For the analyst such action was a serious technical breach denoting countertransference and an imperative signal to seek more analysis.

Over those years and since, many of us on both sides of the ocean and from often diverse theoretical bases have wrestled with these austerities, as did Ferenczi (1930), Balint (1952), and Winnicott (1965) before us. Clearly, many of us have shaped our technical modes in accord with our idiosyncratic preferences and derived the theories that best support our choices. It is both invigorating and burdening that we have made of ourselves a polyglot lot in a polytechnical field.

Yet, whatever our orientation, we obviously continue to need ethical restraints to counter the therapist's self-motivated and potentially destructive inclinations and to assert sufficient authority to help patients contain their urgencies. The thorny tangles of overtly sexual/aggressive enactment continue to make it hard for us to explore the technical assets and liabilities of other levels of physical contact.

We are fortunate that Casement's topic of handholding offers us a thistle, not a bramble. His 1982 paper was and remains a clear and compelling call to the analyst to hold fast to the classical position. Supported by appropriate and vivid clinical data, Casement gives us a fine depiction of the depth and quality of analytic therapy that can be accomplished within this framing.

I wish to challenge his position of theoretical and technical certainty that the proscription of touching is the only valid stance for effective analytic work.

I want also to demonstrate that the analyst's resort to preferred theory can be a protective retreat from affective intensities, in self and patient, and thus an impairment to the analyst's capacities to handle ambiguity and uncertainty.

Finally, I want to emphasize, using Casement's clinical vignette and one of my own, the clinical importance and dynamic implications for both patient and analyst, of sequential traumata triggered by the analyst when the analyst's pursuit of own theoretical bent blunts optimal attention to the patient's unaddressed concerns.

In his 1982 paper Casement provided significant details from the months of interactive analytic work with Mrs. B that immediately preceded her moment of pleading. Because these details are not included in the version I am considering here (Casement, 1991), I shall summarize them here as context essential to this discussion.

We learn that Mrs. B had for the first time begun to come to grips with a chain of traumata to which she had previously only casually alluded. These events began with hot water scalding over much of her body at the age of 11 months, followed by her mother's anxious care and culminating in surgical reduction of her scars under local anesthesia at the age of 17 months. Now feeling better about herself, Mrs. B had tentatively proposed dropping her fourth analytic session. Casement's quick acceptance, along with other behaviors, led her to become very anxious and explicit in pointing to selfish motives on his part. He dealt carefully and effectively with the consequences.

Casement shows here how he is working in ways that accord well with an ideal he endorses in his *Learning From the Patient* (1991): to subordinate one's theoretical givens for the sake of fathoming the patient's concerns and point of view. He monitors his own partial identifying with Mrs.B. in order to sense what his actions might have stirred in her. He puts into words, for her to react to, what these meanings might be for her now. This work fosters in Mrs. B an emergent state of enhanced trust, hope, and vulnerability that she brought with her to the sequence that we will now consider. I want to stress the importance of this state as the context for two traumatic sequences that ensue. Because Casement has given an account of these events in Chapter Seven of *Learning From the Patient*, I shall make only allusive reference to them in what follows.

The first sequence opens with his account of his patient's reporting having dreamed about a despairing child and now wondering about the child's despair. Casement follows his own bent in inquiring into the patient's past, persisting despite her gesturing him to stop. Mrs. B falls into silent terror.

These details convey how Casement has shifted from his patient-centered stance to a more theory-determined bent that actualizes Mrs. B's worst fears. He describes being under huge pressures from the patient and from within himself. Casement this time does not address his contribution to her distress.

This first trauma shows the shape and purpose of a time-honored analytic given: the patient's manifest concerns are a defensive screen that must be overcome.

A second trauma occurs in the next session, prompted by Mrs. B's pleading to know if she will be allowed to hold Casement's hand, so that she might continue to explore the scalding disaster. Casement ambivalently accedes. Over the ensuing weekend he reconsiders and retracts his half-offer when next they meet. On being told, Mrs. B regresses profoundly, and over several sessions is suicidal and delusional. Casement holds firm and is persuasive. Eventually, Mrs. B calms, accepts the correctness of his stance, and feels better.

Let us now turn from Mrs. B to contrast and compare her course with a case of mine.

This piece of analysis with Mrs. M dates from a time in the late 1970s when, like Casement, I was examining the constraints of my training indoctrinations of the late 1940s. I was caught up then in seeing for myself how aspects of this training had reinforced my preferences for distancing and detachment.

Internal pressures to reconsider my rigorously abstinent stance came from dealing with patients who did not benefit from my austerities. Among them were those who wanted to touch or to be touched by me. I began to have a better appreciation of how my insistence upon nongratification could touch patients in ways at times helpful, at other times damaging to the trust and readiness they needed in order to deepen the analytic work (McLaughlin, 1995). For the latter, my withholding confirmed their worst fears and led to a protracted and stalemated analysis that the two of us could neither resolve nor get beyond.

In a few other instances of high duress, a patient's hand reached out from the couch and I held it without hesitation because it felt right. I waited for the dire analytic consequences of insatiable demands or lost analytic access. Instead, our enactment released in these patients fresh capabilities to drift to their own retrieval of not-yet-sounded recall and then to deal with fresh intensities of ambivalence toward me. Much later, I would hear that such a moment of contact had been pivotal to the patient's consolidating of trust that together we might endure, even prevail. My patient, Mrs. M, offered such a hand.

Clinical Vignette: Mrs. M

An attractive and succesful businesswoman, meticulous in her grooming and speech, Mrs. M carried herself with aloof pride. She was acutely aware that her public face of unruffled competence concealed a torturing self-consciousness and fear of being found flawed. Now in her forties she found little reassurance as wife to a quiet, accepting man, and mother to three latency children. She was too busy to feel depressed, but worn by trying to conceal her anxiety and dread.

A year into a 4-hour a week analysis at the time of the sequences I shall dwell upon here, Mrs. M was vigilantly poised to go silent at any hint of censure by me. I could sense her dread of being shamed by the eruption of her rage and the revealing of sexual intensities. But it was soon evident that these lay beyond her readiness to face them, hidden by her obsessional and self-concealing ways.

She had grown up in poverty on a farm in Appalachia with a brother several years older, who in his early teens had fled to the city. Her rough-hewn and earthy farmer father could be at times gentle with his daughter, but more often was critical or silent, worn down by working the rocky soil of farm and wife.

Mother was a displaced town lady, bound to an uncouth farmer and to a life that denied her any recognition of her rare beauty and superior status. She relentlessly inspected her daughter for flaws that might be worked on. Sadly, these defects were, like those of her father and brother, irreparable and beyond more than camouflage.

Initially, she could retrieve few memories. Happy moments were rare: running into the fields with her father's lunch; being by herself in a quiet meadow. But always the nagging sense that she should be in the farmhouse with her mother.

She gradually revealed, with evident shame, a limited collage of painful memories spread across her early years. These had in common her being the squirming or slumped object of the mother's clutching concerns. Gradually, it became evident that Mrs. M had directed on herself her mother's critical outlook, concealing her rage and protest over a constant depreciation she now warily looked for in me.

An exchange that brought these tensions to the fore will serve as a marker for the month or more of work on which I will focus.

Mrs. M was lamenting her own oppressive anxiety, so like her mother's in her scanning of her deficient world and her daughter who was part of it.

I commented: "Perhaps you felt picked on and ashamed when your mother focused on you?" She quickly denied this and vigorously defended her mother's loving concern and her guilt at having so misrepresented her mother. I asked: "Are you saying instead that your way of keeping a steady check on you, on how you're doing, became your necessary way of keeping a closeness with your mother?"

To this she gave sad assent, relaxed, and went on to her first emotionally rich account of her mother's death some 3 years ago; still missing her so, and more anxiously self-preoccupied.

In the next session she opened up a story from her early school years. Mother had found her scratching her lower belly and discovered body lice. Aghast, she pushed her child away and ordered her off to the barn to her father. Mrs. M now recalled feeling stricken and hardly able to move, banished by her mother as filthy and untouchable. Father matter-of-factly stripped her clothing and inspected her minutely before he immersed her head-to-toe in a washtub of foul-smelling stuff she thought to be sheep-dip. Already numb and passive in his hands, she was overwhelmed with feelings beyond describing, except embarassment and fear that her mother would now find her badness even more unforgivable.

Feeling her silence as stricken and helpless, I reflected aloud and quietly to her my sense that her shaming rejection by her mother could have become so much worse when she was put into such closeness with her father.

Mrs. M was tensely silent for several minutes.She flung herself into a sitting position to burst out in novel and angry vehemence. "You're jes' hurting me worse! Talkin' flat and shoving my face in it! It wasn't close, just him checkin' me out like one of his hound dogs! You're way off, pokin' at me: I feel alone and awful!" Her voice had raised to a near-wail, with an Appalachian drawl I was hearing for the first time. Both her anxious regression and its immediate referents to her story and to me were suddenly in my face. She poured out a vivid summary of my stupid behavior, the first outpouring of criticism that would go on intermittently for much of the analysis.

I was surprised that I had so startled and shaken her, but I could hear a view that seemed to fit both with the experience she had just described and now with my flat probing. So I acknowledged, with considerable feeling, how I could see how I had hurt her with my off-target comments that left her feeling I was poking and inspecting her. I wondered how I might have done differently?

After an interval of grumpy silence, Mrs. M relaxed a little to indicate she didn't much know, but she sure didn't want me to carry on like her father! She knew this all had more to do with her mother, and was I havin' trouble hearing this? I replied that she certainly had my attention, and let us see.

Mrs. M, back on the couch, continued for a week or so to set me straight, in acid tones informing me of the many ways I was failing to appreciate her mother's good qualities. In the heat of telling me off, she would be silent and then berate herself for her badness in speaking ill of her mother.

I was largely silent. After she had slowed down into what seemed like fatigued silence, I commented that there was such hurting and near giving-up in her struggle to be comforted, not treated as defective. And all the while she in turmoil over not knowing where to put the angry blaming: on herself or on me. I know there was a quality of a lament in how I spoke, for I was feeling hammered and uncertain.

Mrs. M stiffened at first and then visibly relaxed and began to cry silently; she seemed dazed and for the rest of the hour was silent.

In the session that followed, she was anxious, hesitant, and tremulous in attempting to speak of what she had come upon in yesterday's hour. She had heard what I said and had become overwhelmed with a confusion of feelings beyond her naming. Maybe soothed a bit, but also anxious and afraid to speak. And there were indescribable body sensations about which she was not ready to speak and might never be. She remained in this anxious state for several sessions, wary and silent. What had felt to me like a perhaps placating but nonthreatening response had for Mrs. M been obviously traumatic. I could not immediately sense how this trauma had come about, so I grew silent, too.

In my silence I felt a mixture of moderate shame and guilt and a concern over having done harm. This cluster was by now a familiar signal to me, in times of strain, as a reminder of experiences in childhood of having blundered into behaving in a manner that had been hurtful to another and shaming to me (McLaughlin, 1995, p. 452). I was taken aback to see that my prized commitment to a patient-cen-

tered stance, intended to locate and speak to her distress, had been traumatic in my going beyond her capacity to defend against yearnings for closeness and comfort that, in her anger and fear of being shamed, she still needed to ward off.

Not a prolific dreamer, Mrs. M brought in several snatches of disturbing dreams spread over these hours: muddy manure in the barn and the cows restless; she anxiously running and hiding in the hayloft, but no way to clean her dirty boots and overalls, and nobody to turn to. Sounds of keening, high-pitched wailing all around her, and she unable to run away, or to move her body at all. I could do little with these fragments except to reflect her need to hide from what seemed too soiling for her ever to make right on her own.

She drifted into an experience about which she had no personal knowledge but had learned from her mother's oft-told stories about disgusting events that she had to put up with in her daughter's early rearing. This one had to do with pinworms. Her mother one morning had found her sitting in a squirming mass of worms and feces, absorbed in fingering herself and them.

At this point Mrs. M suddenly flung both arms above her head as she began a near-wordless wail. I could make out: "Can't do this!—Mama!—Alone—Gone!—I need!" Her right hand was now close to me and I took it in mine, without speaking. She was tense and silent a few seconds and then held on as she haltingly resumed.

Her mother had circled her, near to vomiting, not touching. Both now screaming and she reaching out to be picked up; mother gone from the room, shouting for father to get back from the milking.

At this point Mrs. M pulled her hand away, sobbing as she covered her eyes. She haltingly found words about her father's stomping into the room, holding her up to inspect her bottom; how he wiped her clean and stripped her and the crib; soon some foul-tasting stuff to drink and more poured in her washtub. As she spoke, she continued to cry but grew less agitated. As she sat up to leave, she appeared spent and dizzy.

She opened the next hour with a wan smile and brief comment: "We got somewhere yesterday, but looks like there's more to go." On the couch, she dwelled on the previous hour in a reflective fashion. She felt rescued, "lifted a little out of the muck, not stuck; able to breathe, to move." She felt grateful, but uneasy. She had a fragment of a dream of last night that seemed so real: very small and in

a white dress for church, running off to show her father down at the barn; slipping on a fresh cowpad and sliding through it on her bottom. Now it *was* real: her mother screaming and angry, holding her by her collar at arms-length to dump her in the pump tub until her father could arrive.

Mrs. M again grew agitated, but this time in a breakthrough of anger at her mother, increasing in pitch as she got to: "Why couldn't she see it wasn't my fault! Not the same as when I'd mess my drawers and it *would* be my fault, and she wouldn't talk to me." In the midst of this tirade Mrs. M slapped her forehead as she blurted out that she still couldn't trust that I would put up with her without turning on her. I noted to her that she had surely stopped herself cold with her whack on her head. And it sounded like it might have hurt. What did it seem like to her?

Mrs. M responded to my deflecting intervention by insisting that the gesture meant nothing. For a week or so, she haughtily chastized me for my intrusion, appearing aware of her struggle over revealing more or covering over. But she did come back to her headslapping. She connected it to her fresh memories of being batted on the head or slapped in the face by her mother for her badness in wanting to be off with her father, gallivanting with brother, or showing any anger or rebellion.

A second episode around touching soon took shape. Mrs. M asserted her intention to come to grips with her persisting sense of being deeply bad and unlovable. She couldn't make headway, except to know that this feeling once more related to her bottom. But it was more pervasive, involving all of her being, deepening her sense of shame and self-blame.

She had fresh images of her mother peering down on her in her bed. This time her mother raged in shocked disbelief as she caught her daughter, now 10 and abed in the morning, in the act of fondling her genitals.

At this point in the telling Mrs. M began to reach back toward me. As we almost touched, however, she quickly jerked her arm back and slapped her forehead, crying "No! it's bad, it's a sin! I'm bad!"

I spoke with intensity about "so bad that until now you daren't speak of it or think about it—just keep it hidden away?"

Mrs. M after awhile continued. Mother had stripped the covers off and was horrified at seeing secretions that she declared to be

another kind of infection. She insisted that the father touch and inspect their daughter's external genitals but was not pacified until a housecall by the local doctor. He probed and looked, assured the mother that Mrs. M was not infected and no damage visible. Again becoming very upset in the telling, she remembered that her mother, instead of quieting down, had gone into a cold and silent rage and confined her to the house. She shunned her daughter for what seemed like a lifetime, probably a week, neither looking at or speaking to her. Father must have withdrawn to his barn and fields during this siege, for Mrs. M had no recall of his presence or support.

In living through this session and those that followed over the ensuing week, Mrs. M fell into long silences. Gradually she recalled that her old masturbatory excitement and play had begun with her first worm infestation and had continued with little conflict. But images of her father's exciting roughhousing and matter-of-fact handling of her infested body had begun to intrude, becoming both too arousing and soothing as she grew older. It was then that she had grown guilty and fearful of what might happen were her mother ever to discover the unmanageable turmoil boiling inside her. Then Mother did catch her. This time her mother's prolonged punishing fixed her belief that her sexual feelings for her father were forever beyond forgiveness by either parent and proof of her low animal nature.

Our ensuing reworking of these traumatic times took several weeks, she painfully recalling their details, and I continuing to seek words that would find a fit with her affective states then and now. She would berate me when I was off the mark, relax and nod assent when I "finally got it right."

In this context she was gradually able on her own to connect her mother's oppression with what she had been seeing in me, but now realized was different: being under my thumb that was "not so big as Mother's thumb."

Mrs. M began for the first time to show flashes of playful humor and to needle me with pointed wit, happily watching her hands dancing as she spoke of newfound freedom. She was certain that I, too, was watching and pleased.

In time she told me with feeling that my first holding of her hand had stayed in her mind as she made her way through the incidents that followed. She could not have found her way without it. And she finally had figured out what felt wrong about wanting our second

touching at the point when she was speaking of the masturbatory incident. She now remembered that Father, in inspecting her genitals, had muttered to her something like, "Nothin' wrong with your bottom: pretty as a lil' pink porker. But don't tell her I told you!" Mrs. M had felt joy, then excitement, shame and guilt, and had to put it all out of her mind. Now it was easy. And the oedipal aspects of her analysis went on to unfold without great turbulence.

Discussion

It seems evident enough that both Casement and I inflicted a sequence of traumata upon our patient. Casement does so through his commitment to the stance of analytic abstinence and avoidance of gratification of regressive desires. I do so through my commitment to seeking and affirming the patient's viewpoint and affect. Both of us hold our respective stance to be essential to the optimal retrieval of the troubled past.

However, under mounting tension between patient and self, the over-zealous use of our preferred stance both wounds the patient and interferes with our fully responding to the patient's distress. When such traumata are repeated and go unaddressed, the patient falls into mounting distress and destabilization. Others have noted the importance of this sequence (Winnicott,1965; Kohut,1971; Schwaber,1986).

It is our overuse of technical perspective, under times of stress in both our instances, that will provide my focus in dwelling on the dynamics, both intrapsychic and interpersonal in our patients and ourselves, that shaped the sequence of painful circumstances.

But first, a brief digression about the merit of thinking of these happenings as traumatic. We all know that any behavior of the analyst can prompt discomfort of varying degrees in our patient and that these responses need carefully to be addressed by us. Distress for the patient that is set off by the analyst can accurately be described as traumatic when the patient becomes overwhelmed by affect and destabilizes toward clinically evident nonverbal states. Confirmation comes when the patient restores enough to tell of having felt shocked, stunned, and unspeakably anxious. The crucial contribution of the transferred past becomes evident when the patient also conveys the confusion of experiencing analyst and self as now too much like the past and unbearably different from the wished-for better.

This confluence of past and immediate traumata is vividly portrayed in our work with Mrs. B and Mrs. M. Both patients had experienced significant traumata in early years and beyond: Mrs. B's acute, and occurring specifically during the beginning of her second year of life; Mrs. M's in the category of chronic strain beginning at least in her early toddler times, with acute episodes repetitively encountered from early childhood on. (I am drawing here upon Kris's [1956] still useful distinctions on the nature of early trauma, drawn some 40 years ago.) The traumata for both had to do with reactions of the mother to physical defects or damage, in which the mother withdrew, showing revulsion, anxiety, and rejection-abandonment.

The critical moments for ourselves and our patients came just when the patient appeared to have built up sufficient hope and trust to venture into working on tensions embedded in these old traumata. It is in such moments of deepening intimacy that fresh emotional intensities arise between the analytic pair. These hold promise, yet also the risk of heightened ambivalences in both and the liability to regressive enactments (McLaughlin, 1991).

At such a moment the patient is especially vulnerable, since her need and desire for nurturing closeness is countered by more familiar and fearful expectations of its opposite. The analyst also is vulnerable, for he is on unstable and ambiguous ground, where his own libidinal and aggressive tensions around deepening involvement may evoke anxieties about himself or his patient.

If traumatized at such a moment and her regressive responses go unheeded, the patient is prone to escalate her distress. In her ambivalence she is liable to more primitive and varied preverbal urgencies more concretely expressive of her conviction that the old trauma has recurred. The demand for physical contact becomes one such conspicuous expression.

This sequence can be seen in our respective vignettes. Both Casement and I, just after having worked with sufficient analytic sensitivity that our patients showed cautious readiness to go further, now clearly lose touch with these more evolved and discriminating analytic capabilities that we hope to have made our own.

We jarred and put off our patients with well-intended and accurate enough interventions that carried the mark of theoretical bent: Casement with his quick acceding to a shortened schedule, I with my misguided oedipal intervention about too much closeness to her father, as we were working over the body lice episode.

Both of us were able to retrieve these misadventures well enough, so that both patients resumed their ambivalent venturing. Neither of us cites personal reasons for our shift. Often, these slippages can later be seen as an early signal that the analyst is heading into trouble about which he or she is not yet consciously aware.

Complications soon arose that became much more traumatic for our patients, traumata that we contributed to in ways that turned out to be painfully reminiscent of those old experiences specific to the patient's deepest concerns.

As Mrs. B ventures to open up the story of her scalding, Casement overrides her gestured plea to stop. She becomes unbearably anxious, sees him as indeed the surgeon on whose couch/operating table she is afraid to lie. He does little to address her distress on her terms. Soon she pleads for his promise of physical contact.

The second traumatic event builds from the first as Casement, after feeling moved to a half-promise to comply, withdraws his offer in order to stand fast to his commitment to abstinence. Mrs. B reacts with shock, massive destabilization, and persisting regression. Eventually she restores to a better level and agrees with his views of the work accomplished.

In the instance of Mrs. M, traumata of my doing can be seen that are similar in a sequential sense to those of Casement's instance. But there are differences in the nature of the dynamics and underlying affects between Mrs. M and me and in her responses to my ways of meeting her needs.

The first shocking episode came in a moment of silence during her prolonged rage response to my oedipal-level intervention. In that silence I had intervened to lament the pain of her dilemma over whether to blame me or herself. This proved traumatic in its evoking shock and withdrawal from feelings and bodily sensations that were too positive for her yet to handle in her high level of ambivalence.

I withdrew to silence and did not sufficiently stay with her, shaken by her response, which made me realize that my technical interest in my patient-centered stance, intended to locate and speak to the pain of her dilemma, had become a liability. I believe that this intermingling of her heightened distress and my perplexed withdrawal led her to regress to urgencies demanding physical contact as the expression of her conflict over needing and fearing what my intervention held out to her. This was the context in which her nonverbal plea to hold my hand became urgent.

Here was the second trauma-in-the-making, but one that did not crescendo. My unthinking grasp of her reaching hand shocked her, reflected in her dazed state and struggle to keep working. Yet she was able to go further into her recall in a useful fashion, her verbal capacities for the usual analytic work restored. So far as I could see then, and now reflect upon, the handholding was far more sustaining to Mrs. M than traumatic and enhanced the depth and scope of the analysis. Our holding hands went on through the recall of the pinworm event up to the point in her description when her mother left and her father took over.

In retrospect she had felt that the handholding provided a sense of a mothering acceptance, firm and sure, that "allowed" her to face her mother's abandoning her back then as untouchably loathesome. Mrs. M's word seemed to capture an essence of her desperate need to find acceptance while facing her rage and protest revealed by telling on her mother. Further evidence of the usefulness of our handholding lies in the unfoldings that followed. In the later episode of dirtying her dress and provoking her mother's wrath, Mrs. M openly expressed her rage and rebellion toward her mother and comfortably handled my intervention about her head-slapping that diverted us from her attack upon my untrustworthiness.

She could move on her own to take up the miseries of her discovered masturbation. Though later in developmental time than the preceding, this episode captured her necessity to confront her mother with her emerging pubertal sexuality and to dare, at whatever cost, to risk new levels of her mother's rejection and shunning. It was at this point in her story that Mrs. M made her second appeal for handholding and then pulled back in distress before our hands could touch. Both her words and actions conveyed now-triangular conflicts in her relation with both parents and with me as the embodiment of both. Mrs. M showed no further need for handholding as she went on to work through these oedipal concerns, back then and now with me, with less than usual turbulence.

I feel comfortable in the notion that once she had resolved, through and with me in our work, the excessive ambivalence in her attachment to her mother, she could turn rather comfortably to sort out her feelings toward her essentially nonthreatening and accepting father, whom all along she had hoped to find in me. She remained sure that our way of getting through the traumata of her past was crucial to the course of her analysis.

Let us return to differences between Casement and me over technique and theory as these are reflected in the examples we have offered. Both of us show that at crucial times we behaved in ways that were, to some degree, painful and traumatic for our patient in pressing them beyond their defensive capacities, yet each of us feels that our particular way was ultimately helpful.

Our two examples bring out an intriguing difference in the nature of the trauma. Casement traumatizes Mrs. B with deprivation she cannot handle. I traumatize Mrs. M with gratification she cannot handle.

Casement works from a conviction that his method of deprivation evokes the pain that belongs to the original trauma and is necessary if the patient is to recall and repeat what Casement emphasizes is "*the experience as it had been*" (his italics). In this veridical retrieval he sees himself as the good analyst who is instrument and arbiter of the deprivation, but not primary to its happening, despite his patient's conviction to the contrary.

I work from the position that the patient's experience of my behaviors as traumatizing needs to be accepted as valid in its own right and not arbitrarily seen as a transferred reflection of past trauma. I accept my impact as iatrogenic, a misstep of my own until subsequent exploration shows otherwise. By otherwise, I mean the extent to which we come to see that my behaviors have contributed to and compounded the patient's old fears and expectancies. It is this confluence of our driven pasts that we explore together, and I separately in my attempts at self-scrutiny. From this position I cannot envision that we come upon the past in its pristine form.

Casement sees any lapse from his abstinent mode as evidence of his having caved into patient pressures to have him act like a good mother, and the consequences are dire. Yet he does not acknowledge that his abstinent behavior might cast him in the identity of unheeding parent or surgeon. I see as inevitable that whatever I do or don't do reflects some of the shifting mixtures of gender configurations that I carry. Whether these doings make me a good or bad mother, father, or whatever, this is for the patient to experience and for me to address as phenomena we have shaped between us out of our intermix of our present and past.

We are very much at odds, Casement and I, about how we see ourselves in what we did in the critical interactions described. From his position, my handholding with Mrs. M could be seen as behaving

like a good mother and hence impeding the work. From mine I can look upon his deprivations as his behaving as the surgeon whose persistence may carry the day, but at a price that is open to question.

We differ also in how we think about our internal stresses that we encountered with these patients. He looks upon his near succumbing to his patient's plea and his later sense of helplessness as reactions to the power of the projective identifications she is putting upon him. He must extricate himself by resolutely retrieving his abstinent stance. From my bias I see his resort to his theory as sidestepping the personal implications of both his near-lapse into a gratifying mode and his insistence upon being the depriving analyst. Both could offer insights worthy of his attention.

Like Casement, I find value in looking upon my intrusive interventions with Mrs. M as my responses to her projective identifications. I find a richer yield in first viewing these responses as likely to reflect my defensive need to ward off conflicts of my own. I hold that my conflicts around intimacy and concerns over hurting and being hurt were amplified, not caused, by what I felt to be the pressures she was putting upon me in her regression.

I am alluding here to the primary importance of the analyst's needs to attend to the blindspots of his or her own conflicts that interfere with a sustained attention to the patient. As I have noted elsewhere (McLaughlin,1988), these defensive blindspots underlie much of our defaultings, including retreat to the protective rigidity of some of our established practices.

In those times of stress and ambiguity such as we have separately described, Casement finds it best to keep to the certainty of rules that simplify the practice and justify the nature of its outcome. In these matters I prefer to risk what feels right, to gamble with consequences I do not comprehend enough to prejudge, and to deal as openly as I can with the consequences of working in a two-part confluence.

There can be no conclusions to be drawn from all this. There can only be questions still to be addressed. We will do well when we continue to test our theories and our practices in the field trials of clinical practice and show our work in our colleagial discourse. We will do even better at this when we keep looking at the very personal motives in us that shape our preferences and drive us in the defense of our choices.

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